U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 10 March 2004

Case No. : 2000-BLA-0059

BRB No: 02-0669 BLA

In the Matter of:

CARRIE E. DEVINE, Widow of and o/b/o
the Estate of GEORGE M. DEVINE, JR.,
Claimants

v.

PEABODY COAL COMPANY,
Employer

OLD REPUBLIC INSURANCE COMPANY,
Carrier

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest

Before: Robert L. Hillyard
Administrative Law Judge

DECISION AND ORDER ON REMAND - DENIAL OF BENEFITS

On May 29, 2002, the undersigned Administrative Law Judge issued a Decision and Order in the above-entitled proceeding denying benefits on a claim filed pursuant to the provisions of Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901, *et seq.*, hereinafter referred to as the Act. On appeal by the Claimant, the Decision was affirmed in part and vacated in part and the case remanded to the Office of Administrative Law Judges by Decision and Order of the Benefits Review Board, BRB No. 02-0669 BLA, issued on June 24, 2003.

The Findings of Fact and Conclusions of Law stated in the original Decision and Order are adopted herein except to the extent they were found to be erroneous by the Benefits Review Board, or to the extent that they are inconsistent with the findings and conclusions made in this Decision and Order on Remand.

Discussion and Applicable Law

In its Decision and Order, the Board reviewed both the Miner's claim and the Survivor's claim.

In review of the Miner's duplicate claim, the Board held that I improperly analyzed whether a material change of conditions occurred by reviewing newly submitted evidence to determine whether the Miner was totally disabled due to pneumoconiosis. The Board stated that:

> Because the relevant inquiry in the instant case is whether the newly submitted evidence establishes total disability, without regard to the cause of any disability … and since the administrative law judge's material change in conditions analysis does not include an evaluation of Dr. Norsworthy's opinion diagnosing a severe pulmonary impairment … we vacate the administrative law judge's finding pursuant to Section 725.309 (2000), and remand the case for further consideration of the material change in conditions issue. On remand, the administrative law judge must determine whether claimant has established a material change in conditions, i.e., whether the newly submitted evidence is sufficient to establish that the miner suffered from a totally disabling respiratory or pulmonary impairment pursuant to 20 C.F.R. § 718.204(b).

Devine v. Peabody Coal Co., BRB No. 02-0669 BLA 5 (June 24, 2003).

The Board went on to vacate the findings of the x-ray evidence pursuant to § 718.202(a)(1), and the findings of the medical opinion evidence pursuant to § 718.202(a)(4). *Devine*, BRB No. 02-0669 BLA at 8, 10, 11.

Pursuant to § 718.202(a)(1), the Board held that the x-ray interpretation of Dr. Sargent was mischaracterized and not all of the relevant evidence of record was considered in reaching

the findings. *Id.* at 8, 9. "Accordingly, the administrative law judge must reevaluate the x-ray evidence, if reached, on remand." *Id.* at 8.

Pursuant to § 718.202(a)(4), the Board held that I did not consider all of the relevant medical opinion evidence of record and improperly weighed the opinions of several physicians of record. *Id.* at 10, 11.

Upon remand, therefore, I must evaluate the duplicate Miner's claim to determine whether a material change in conditions has occurred, as described above. *See also, Sharondale Corp. v. Ross*, 42 F.3d 993, 19 B.L.R. 2-10 (6th Cir. 1994). If the Claimant establishes such a change, I must analyze the evidence, new and old, in accordance with the Board's directives regarding the existence of pneumoconiosis under § 718.202(a)(1) & (4) to determine if the Claimant is entitled to benefits.

Medical Evidence

As the Board made extensive and specific comments regarding the x-ray evidence and the medical narrative evidence, those reports are stated here for analysis. The pulmonary function study and arterial blood gas study evidence is incorporated by reference.

X-ray Studies

	Date	Exhibit	Doctor	Reading	Standard
1.	1/26/99	DX 9, 10	Park	Pneumo. not noted	Not noted
2.	1/26/99	DX 12	Sargent B reader[1] Board cert.[2]	No pneumo.	Good

[1] A "B reader" is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successfully completing an examination conducted by or on behalf of the Department of Health and Human Services. *See* 42 C.F.R. § 37.51 (b)(2).

[2] A Board-certified Radiologist is a physician who is certified in Radiology or Diagnostic Roentgenology by the American Board of Radiology or the American Osteopathic Association. *See* § 718.202 (a)(ii)(C).

3.	11/24/98	DX 9, 10	Sison	Pneumo. not noted	Not noted
4.	11/24/98	DX 12	Sargent B reader Board cert.	No pneumo.	Good
5.	9/23/98	DX 27	O'Bryan	Category 1 pneumo.	Not noted
6.	8/6/98	DX 27, p. 36	Wheeler	No pneumo.	Fair
7.	8/6/98	DX 27, p. 38	Wiot B reader Board cert.	No pneumo.	Good
8.	8/6/98	DX 27, p. 59	Sargent B reader Board cert.	1/0 s/p	Poor
9.	8/6/98	DX 27, p. 60; DX 9	Westmoreland	Pneumo. not noted	Not noted
10.	8/6/98	DX 27, p. 61	Simpao	2/2, p,p	Good
11.	11/22/91	DX 9	Fulton	Pneumo. not noted	Not noted
12.	11/22/91	DX 12	Sargent B reader Board cert.	No pneumo.	Poor
13.	11/22/88	DX 12	Sargent B reader Board cert.	No pneumo.	Poor
14.	4/15/86	DX 26	Baumgarten	Pneumo. not noted	Not noted
15.	6/29/83	DX 26	Not noted	No pneumo.	Not noted
16.	5/24/83	DX 26	Trover	"Pneumo. category 1p"	Not noted

17.	5/24/83	DX 27	Gallo	Pneumo. category 1p	Good
18.	3/1/83	DX 26	Felson[3] B reader Board cert.	No pneumo.	Good
19.	1/8/83	DX 26	Wiot B reader Board cert.	No pneumo.	Poor
20.	1/8/83	DX 26	Cole B reader Board cert.	2/1, p,s	Fair
21.	1/8/83	DX 26	Stokes Board cert.	3/2, p	Good
22.	10/18/82	DX 26	Anderson	Category 2 pneumo.	Not noted
23.	9/13/82	DX 26	Beck	Pneumo. not noted	Not noted
24.	8/6/82	DX 26	Not noted	Pneumo. not noted	Not noted
25.	3/26/79	DX 26	Smock	Pneumo. not noted	Not noted
26.	11/19/73	DX 26	Coffman	Pneumo. not noted	Not noted

Examination Reports

1. a. Dr. William M. O'Bryan examined the Miner on September 23, 1998, at which time he reviewed the Miner's symptoms and his medical history (dyspnea on exertion; "coughs daily brings up mostly yellow phlegm"), and performed a physical examination, pulmonary function study, arterial blood gas study

[3] Dr. Felson was deposed on June 2, 1983, at which time he recounted his earlier findings and opined that the Miner's March 1, 1983 x-ray showed no evidence of coal workers' pneumoconiosis (DX 26).

("O_2 saturation at rest is 99% and post exercise is 97%"), and interpreted an x-ray ("background of a category 1 pneumoconiosis with cardiomegaly"). Dr. O'Bryan diagnosed: (1) right lower lung mass, strongly suspect a primary carcinoma of the lung; (2) restrictive lung disease secondary to pneumoconiosis and possible IPF, severe impairment; (3) organic heart disease status post-CABG; (4) oral-agent dependent diabetes; and, (5) hypertension (DX 9; DX 27, pp. 50-51).

b. Dr. O'Bryan wrote a letter to Dr. Norsworthy following his examination of the Miner on September 23, 1998, in which he opined that the Miner "does have a category 1 pneumoconiosis. In addition to this, he has a mass in his right lower lobe which needs further evaluation" (DX 9).

2. Dr. Valentino S. Simpao examined Mr. Devine on August 6, 1998, at which time he reviewed symptoms and occupational (35¼ years coal mine employment), medical (coughs up greenish-yellow and bloody sputum; wheezing; dyspnea at rest and exertion; chest pain on exertion), smoking (smoked two packs per day from 1961 to 1975), and family histories, and performed a physical examination, pulmonary function study (moderate degree of both restrictive and obstructive airway disease), arterial blood gas study (normal), and interpreted an x-ray ("CWP 2/2 - abnormal - well defined soft tissue mass RLL"). Dr. Simpao diagnosed "CWP 2/2," based on the Miner's "multiple years of coal dust exposure … findings on chest x-ray and pulmonary function test along with physical findings and symtomotology [sic]." In his opinion, the Miner has a moderate pulmonary impairment related to pneumoconiosis and does not have the respiratory capacity to perform the work of a coal miner or to perform comparable work in a dust-free environment, based on "objective findings on chest x-ray and pulmonary function test along with symptomotology [sic] and physical findings as noted in the report" (DX 27, pp. 53-56, 58).

3. a. Office visit notes from Dr. Eric Norsworthy[4] dated from 1986 through 1999 diagnose coal workers' pneumoconiosis, COPD, hypertension, pulmonary malignancy with extensive metastatic disease, and presumed bladder malignancy (DX 9).

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[4] Prior to 1986, the Miner was treated by Dr. Robert E. Norsworthy. Dr. Robert E. Norsworthy died, and his son, Dr. Eric Norsworthy, began treating the Miner in 1986 (CX 1, p. 4).

b. Dr. Eric Norsworthy issued a response to questions posed by OWCP on May 11, 1999. He wrote that the Miner "had both chronic obstructive pulmonary disease + coal workers' pneumoconiosis," and that the Miner's death was caused or hastened by his exposure to both cigarettes and coal workers' pneumoconiosis (DX 11).

c. Dr. Eric Norsworthy testified by deposition on October 31, 2001, at which time he stated that the Miner was diagnosed as suffering from coal workers' pneumoconiosis by Dr. Robert E. Norsworthy and Dr. Anderson, a Pulmonologist, and that he later diagnosed the Miner as suffering from coal workers' pneumoconiosis based on his treatment of the Miner and the Miner's x-rays and symptoms (CX 1).

d. Dr. Eric Norsworthy testified by deposition on January 11, 2000, at which time he stated that he treated the Miner from April 15, 1986 until the Miner's death in 1999. Dr. Norsworthy stated that the Miner related to him that he had been previously diagnosed with coal workers' pneumoconiosis when he came under his care. Dr. Norsworthy opined that the Miner's bladder cancer "may have resulted from inhalation of lime dust used to press coal dust in the coal mines" (EX 4).

4. a. Hospital records from Ohio County Hospital dated from January 26, 1999 to January 31, 1999, include reports by Drs. Norsworthy, Desai, and Park which discuss treatment of the Miner for pulmonary malignancy with extensive metastatic disease and presumed bladder malignancy. These records do not diagnose or mention pneumoconiosis (DX 9, 10).

b. Dr. Bruce E. Burton performed a CT scan of the Miner's chest on August 20, 1998 at Ohio County Hospital and did not mention pneumoconiosis (DX 9, 10).

c. Hospital records from Ohio County Hospital dated June 2, 1998 include a report by Dr. William C. Harrison regarding pain in the Miner's left hand and do not mention pneumoconiosis (DX 10).

5. a. Dr. William H. Anderson, a Board-certified Internist and Pulmonologist, examined the Miner on October 18, 1982, at which time he reviewed the Miner's symptoms and his occupational ("35 years in mining, all hauling coal on surface mining"), medical (short of breath, productive cough, chest pain on exertion), smoking ("started smoking at age 40, between 3/4 and one pack of cigarettes per day"), and family histories, and

performed a physical examination, pulmonary function study ("[h]e was not sufficiently cooperative as to allow us to achieve reportable results"), arterial blood gas study, and interpreted an x-ray ("category 2 pneumoconiosis"). Dr. Anderson diagnosed: (1) category 2 pneumoconiosis, based on the Miner's chest x-ray; and, (2) symptoms of arteriosclerotic heart disease (DX 26).

b. Dr. Anderson was deposed on October 3, 1986, at which time he recounted the findings of the February 28, 1986 report. Dr. Anderson reviewed the findings of his October 18, 1982 report and stated that, upon review of the entirety of the medical evidence, it is his opinion that the Miner does not have pneumoconiosis or any permanent pulmonary impairment, and he retains the pulmonary and respiratory capacity to perform his usual coal mine work (DX 26).

6. a. Dr. Thomas A. Gallo, a Board-certified Internist and Pulmonologist, examined the Miner on May 24, 1983, at which time he reviewed the Miner's symptoms and his occupational ("worked 36 years in the strip mines"), medical (short of breath, chronic productive cough, hypertension), smoking (one-half to one pack of cigarettes per day for the past 20 years), and family histories, and performed a physical examination, pulmonary function study (no optimal tracings), arterial blood gas study (normal), interpreted an x-ray ("bilateral reticulonodulation compatible with pneumoconiosis, Category 1p"), and EKG (no diagnostic changes). Dr. Gallo diagnosed "coal worker's pneumoconiosis, category 1p" and "chronic bronchitis" (DX 26).

b. Dr. Gallo testified by deposition on April 19, 1984, at which time he recounted his earlier findings and opined that the Miner had coal workers' pneumoconiosis, category 1p, based on his years of exposure in the coal mining industry and his chest x-rays (DX 26).

7. a. Dr. Emery Lane, a Board-certified Internist, testified by deposition on June 6, 1983, at which time he recounted the findings of his March 1, 1983 examination of the Miner and opined that the Miner had no evidence of pneumoconiosis and retained the pulmonary capacity to perform manual labor as a coal miner (DX 26).

b. Dr. Lane reported that he examined the Miner on March 1, 1983, at which time he reviewed the Miner's symptoms and his occupational (35½ years in strip mining), medical

(pinched nerves in neck, numbness in left arm, shortness of breath, cough), smoking (smoked one-half to one pack of cigarettes per day for about 20 years), and family histories, and performed a physical examination, chest x-ray (0/0), pulmonary function test ("patient unable to cooperate to achieve reportable results"), arterial blood gas study ("very mild hypoxemia"), interpreted an x-ray (0/0), and an EKG ("unremarkable except for nonspecific ST and T wave abnormalities"). Dr. Lane diagnosed: (1) hypertensive cardiovascular disease, under treatment; (2) probable mild congestive heart failure; (3) chronic obstructive pulmonary disease; and, (4) no evidence of pneumoconiosis (DX 26).

8. Dr. Valentino S. Simpao examined the Miner on January 18, 1983, at which time he reviewed the Miner's symptoms and his occupational ("35 years surface mining"), medical (cough, sputum, wheezing, dyspnea, chest pain), smoking (smoked one-half pack of cigarettes per day for 20 years), and family histories, and performed a physical examination, pulmonary function study, and arterial blood gas study. Dr. Simpao diagnosed pulmonary fibrosis and chronic bronchitis (DX 26).

9. Dr. Robert E. Norsworthy[5] examined the Miner on July 15, 1982, at which time he reviewed the Miner's symptoms and his occupational ("employed in mines from 1948 - 1982"), medical (shortness of breath, productive cough, occasional chest pain), smoking ("started smoking when he was 40 years of age and has smoked 1 package of cigarettes per day"), and family histories, and performed a physical examination, pulmonary function study ("markedly restrictive ventilatory defect"), arterial blood gas study, and interpreted an x-ray. Dr. Norsworthy diagnosed "early pneumoconiosis as evidenced from his symptomology [sic] and from his reduction is his PO2 to the lower functional limits at rest," as well as abnormal spirometry and history of exposure. In his opinion, the Miner "is no longer employable at manual labor" because of "his loss of pulmonary reserve" (DX 26).

Consultative Reports

1. a. Dr. Gregory J. Fino, a B reader and Board-certified Internist and Pulmonologist, reviewed medical evidence dated from 1988 through 1999, including 12 readings of chest x-rays dated from November 1988 through January 1999; two pulmonary function tests, dated August 6, 1998 and September 23,

[5] See n. 4.

1998; one arterial blood gas study, dated January 28, 1999; the Miner's death certificate; medical examination reports dated August 1994 through January 1999, including a report by Dr. O'Bryan dated September 23, 1998; a CT scan dated August 20, 1998; and hospital records dated January 23, 1999 through January 30, 1999. He issued a consultative report dated December 15, 1999, in which he opined: (1) there is insufficient medical evidence to justify a diagnosis of simple coal workers' pneumoconiosis; (2) the Miner did not suffer from an occupationally acquired pulmonary condition; (3) there was no respiratory impairment demonstrated; (4) from a respiratory standpoint, the Miner was not disabled from returning to his last mining job or a job requiring similar effort, prior to his development of lung cancer; (5) even assuming that the Miner had medical or legal pneumoconiosis, it did not contribute to his disability, and "he would have been as disabled had he never stepped foot in the mines;" and, (6) "[the Miner] would have died as and when he did due to lung cancer had he never stepped foot in the mines" (EX 3).

b. In a letter dated February 11, 2000, Dr. Fino wrote that there is "no medical literature which establishes a relationship between lime dust and bladder cancer" (EX 5).

2. a. Dr. Ben V. Branscomb, a Board-certified Internist and Pulmonologist, reviewed medical evidence dated from 1987 through 1999, including Dr. Simpao's August 6, 1998 examination report; office progress notes from Dr. Eric Norsworthy dated February 5, 1997 through November 24, 1998; an August 20, 1998 examination report by Dr. Burton; Dr. O'Bryan's September 23, 1998 examination report; hospital records dated January 26, 1999 through January 30, 1999; the Miner's death certificate; and, two pulmonary function tests, dated June 8, 1998 and September 23, 1998. He issued a consultative report dated November 29, 1999 in which he opined that the Miner "did not contract an occupational lung disease associated with coal mine employment," and that "[t]he [Miner's] medical records contain no reasonable objective basis for concluding there was any pulmonary disability prior to his terminal illness." According to Dr. Branscomb, the pulmonary disability suffered by the Miner was due to "rapidly spreading cancer" that was "neither caused, aggravated, or accelerated by dust exposure." Dr. Branscomb concluded that, even if the Miner had simple pneumoconiosis, the record "contains no indication that such pneumoconiosis was disabling," and it did not cause, aggravate, or accelerate his death from cancer (EX 2).

b. In a letter dated January 18, 2000, Dr. Branscomb wrote, "with a high level of medical certainty I know that it is not an accepted concept in medicine that lime [causes] bladder cancer." Dr. Branscomb stated that "it has been well established since at least 1955 that cigarette smoking increases the risk of bladder cancer" (EX 5).

3. Dr. P. Raphael Caffrey, a Board-certified Anatomical and Clinical Pathologist, reviewed nine chest x-ray interpretations, dated from November 22, 1988 through January 26, 1999; medical records from Dr. Eric Norsworthy, dated from 1998 through 1999; Dr. O'Bryan's September 23, 1998 examination report; Dr. Simpao's August 6, 1998 examination report; and, the Miner's death certificate, and issued a consultative report dated November 4, 1999. Dr. Caffrey opined that the Miner "had a significant smoking history," based on Dr. Simpao's report that the Miner "smoked from 1961 to 1975 at two packs of cigarettes per day." Dr. Caffrey wrote that he "could not objectively say" whether the Miner did or did not have coal workers' pneumoconiosis. He opined that the Miner's death was due to carcinoma, and that even if he had pneumoconiosis, it was a "mild degree of simple coal workers' pneumoconiosis [and] did not contribute to or hasten his death." According to Dr. Caffrey, any pulmonary problems that the Miner suffered were caused by his years of smoking cigarettes and then to lung cancer (EX 1).

4. Dr. Echols A. Hansbarger, Jr., a Board-certified Pathologist and Forensic Physician, reviewed "numerous reports of chest x-ray examinations, numerous pulmonary function studies and other items," as well as the Miner's death certificate, and Dr. Wiot's September 18, 1998 chest x-ray reading, and issued a consultative report dated November 2, 1999. Dr. Hansbarger opined that the Miner died "as a direct result of carcinoma of the lung with metastatic disease," and that "[h]e additionally suffered from arteriosclerotic heart disease and chronic obstructive pulmonary disease." Dr. Hansbarger opined that the Miner did not suffer from coal workers' pneumoconiosis or any other occupational pneumoconiosis of the lung, based on a review of the evidence, and specifically on Dr. Wiot's chest x-ray report. Dr. Hansbarger wrote that the "carcinoma of the lung which caused [the Miner's] death was, undoubtedly, related to a long pack year history of cigarette smoking and not related in any way, shape or form to his history of coal mine employment." According to Dr. Hansbarger, the Miner's death was not contributed to, caused by, or hastened by coal mine employment, and, even if the Miner suffered from "a mild focal degree of

coal workers' pneumoconiosis of the simple variety" there was no "impact on his demise since the cause of his death was carcinoma of the lung which is not related to occupational exposure to coal dust" (EX 1).

5. Dr. N.K. Burki reviewed "a copy of all medical evidence in the … miner's Federal Black Lung claim," provided by OWCP on October 1, 1998 (DX 27, p. 48). Dr. Burki issued a consultative report dated October 10, 1998, in which he opined that the Miner had no occupational disease which was caused by his coal mine employment. Dr. Burki wrote that the Miner has no impairment, and that he has the respiratory capacity to perform the work of a coal miner or to perform comparable work in a dust-free environment. Dr. Burki opined: (1) the Miner has coronary artery disease for which he has undergone coronary artery surgery; (2) the chest radiographs indicate no pneumoconiosis; (3) the spirometry tracings are invalid due to suboptimal effort; and, (4) the arterial blood gases are quite normal. According to Dr. Burki, the Miner exhibited, "no radiographic evidence of pneumoconiosis and no objective evidence of pulmonary dysfunction" (DX 27, p. 47).

6. Dr. William H. Anderson, a Board-certified Internist and Pulmonologist, reviewed medical evidence dated from July 15, 1982 through March 21, 1984, including examination reports by Drs. Norsworthy, Simpao, Lane, Gallo, O'Neill, and Penman, as well as arterial blood gas studies and pulmonary function tests conducted by those physicians, and issued a consultative report dated February 28, 1986. Dr. Anderson opined that the Miner does not have any permanent pulmonary impairment and can perform his usual coal mine work (DX 26).

7. a. Dr. Richard P. O'Neill, a Board-certified Internist, reviewed medical records dated from July 1982 through May 1983, including an examination report by Dr. Anderson, dated October 28, 1982; six pulmonary function tests; and, five arterial blood gas studies, and issued a consultative report dated February 20, 1986. Dr. O'Neill opined that the Miner "has no evidence of significant respiratory functional impairment, has no respiratory disability, and … has the respiratory capacity to perform his usual coal mine work…." (DX 26).

b. Dr. O'Neill was deposed on August 23, 1983, at which time he recounted the findings of his June 29, 1983 examination of the Miner and opined that the Miner had no evidence of pneumoconiosis. In his opinion, the Miner suffered from chronic bronchitis due to cigarette smoking (DX 26).

Miner's Duplicate Claim

Material Change in Conditions

The amended regulations contain a threshold standard that the Claimant must meet before a duplicate claim may be reviewed *de novo*.

> A subsequent claim shall be processed and adjudicated under the provisions of subparts E and F of this part, except that the claim shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement … has changed since the date upon which the order denying the prior claim became final…. For example, if the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of this sub-chapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously.

Section 728.309(c)-(d).

The Miner's 1987 claim was denied because the Miner failed to establish that he was totally disabled pursuant to § 718.204(c). To obtain the right to a *de novo* review of his subsequent claim, therefore, the Claimant must first establish that the Miner was totally disabled prior to his death or the duplicate claim must be denied without further review pursuant to § 728.309(c)-(d).

Total Disability

Total disability is defined as the miner's inability, due to a pulmonary or respiratory impairment, to perform his or her usual coal mine work or engage in comparable gainful work in the immediate area of the miner's residence. Section 718.204(b)(1)(i)and (ii).

The Employer concedes that the Miner was totally disabled prior to his death. *See* Employer's Response Brief, p. 12. I find, therefore, that the Claimant has established that the Miner was totally disabled under § 718.204(b)(2). The Claimant has established a material change in the Miner's condition, and the claim must be reviewed *de novo*.

In order to establish entitlement to benefits in a living miner's claim pursuant to 20 C.F.R. § 718, a claimant must establish that he suffers from pneumoconiosis, that the pneumoconiosis arose out of coal mine employment, and that the pneumoconiosis is totally disabling. *See* 20 C.F.R. §§ 718.3, 718.202, 718.203, 718.204; *Peabody Coal Co. v. Hill*, 123 F.3d 412, 21 B.L.R. 2-192 (6th Cir. 1997); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987). Failure to establish any of these elements precludes entitlement. *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986) (*en banc*).

Pneumoconiosis

Section 718.202 provides four means by which pneumoconiosis may be established. Under § 718.202(a)(1), a finding of pneumoconiosis may be made on the basis of x-ray evidence. The record contains 26 interpretations of 16 different chest x-rays. As per the Board's instructions, the mischaracterized interpretation of Dr. Sargent has been amended and the evaluations by Drs. O'Bryan, Anderson, and Gallo have been added to the analysis.

The Board has held that an Administrative Law Judge is not required to defer to the numerical superiority of x-ray evidence, *Wilt v. Wolverine Mining Co.*, 14 B.L.R. 1-65 (1990), although it is within his or her discretion to do so, *Edmiston v. F&R Coal Co.*, 14 B.L.R. 1-65 (1990). However, "administrative factfinders simply cannot consider the quantity of evidence alone, without reference to a difference in the qualifications of the readers or without an examination of the party affiliation of the experts." *Woodward v. Director, OWCP*, 991 F.2d 314 (6th Cir. 1993).

Interpretations of B readers are entitled to greater weight because of their expertise and proficiency in classifying x-rays. *Vance v. Eastern Assoc. Coal Corp., Aimone v. Morrison Knudson Co.*, 8 B.L.R. 1-32 (1985); 8 B.L.R. 1-68 (1985). Physicians who are Board-certified Radiologists as well as B readers may be accorded still greater weight. *Woodward v. Director, OWCP*, 991 F.2d 314, 316 n.4 (6th Cir. 1993).

Only the January 8, 1983 and the August 6, 1998 x-rays contain conflicting interpretations. The January 8, 1983 x-ray was read as negative by Dr. Wiot, a Board-certified Radiologist and a B reader, and as positive by Dr. Cole, a Board-certified Radiologist and a B reader, and as positive by Dr. Stokes, a Board-certified Radiologist. I give greater weight to the

combined readings of Drs. Cole and Stokes and find that the January 8, 1983 x-ray evidence is positive for pneumoconiosis.

The August 6, 1998 x-ray was read as negative by Dr. Wiot, a Board-certified Radiologist and a B reader, as negative by Drs. Westmoreland and Wheeler, who provide no listed expertise in interpreting x-rays, and as positive by Dr. Sargent, a Board-certified Radiologist and a B reader, and as positive by Dr. Simpao, who lists no record x-ray credentials. I give greater weight to the three negative readings of Drs. Wiot, Wheeler, and Westmoreland over the two positive readings by Drs. Sargent and Simpao, and I find that the August 6, 1998 x-ray evidence is negative for pneumoconiosis.

Having resolved interpretation discrepancies, I note that 12 of the 16 x-ray films were read as negative by a mixture of Board-certified Radiologists, B readers, and physicians with no listed specialty in interpreting x-rays. Four of the sixteen x-rays were read as positive. Of the four positive x-rays, only the January 3, 1983 film was read as positive by dually certified physicians (Drs. Wiot and Cole). The other three positive readings are by physicians with no listed specialty in interpreting x-rays.

Taken as a whole, I find the 12 negative interpretations by the more qualified physicians outweigh the less numerous positive readings. I find that the existence of pneumoconiosis has not been established pursuant to 20 C.F.R. § 718.202(a)(1).

Section 718.202(a)(2) is inapplicable because there are no biopsy or autopsy results. Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of the several presumptions are found to be applicable. In the instant case, § 718.304 does not apply because there is no x-ray, biopsy, autopsy, or other evidence of large opacities or massive lesions in the lungs. Section 718.305 is not applicable to claims filed after January 1, 1982. Section 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982.

Under § 718.202(a)(4), a determination of the existence of pneumoconiosis may be made if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. Pneumoconiosis is defined in § 718.201 as a chronic dust disease of the lung, including respiratory or pulmonary impairments, arising out of coal mine employment. This definition includes

both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.

> (1) Clinical Pneumoconiosis. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

Section 718.201(a).

For a physician's opinion to be accorded probative value, it must be well reasoned and based upon objective medical evidence. An opinion is reasoned when it contains underlying documentation adequate to support the physician's conclusions. *See Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which the diagnosis is based. *Id.* A brief and conclusory medical report which lacks supporting evidence may be discredited. *See Lucostic v. United States Steel Corp.*, 8 B.L.R. 1-46 (1985); *see also, Mosely v. Peabody Coal Co.*, 769 F.2d 357 (6th Cir. 1985). Further, a medical report may be rejected as unreasoned where the physician fails to explain how his findings support his diagnosis. *See Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985).

Dr. O'Bryan[6] based his diagnosis on symptomatology, employment history, family and individual medical histories, physical examination, chest x-ray, pulmonary function study, and

[6] Dr. O'Bryan lists no medical specialty credentials.

arterial blood gas study. Based on the information gathered, Dr. O'Bryan diagnosed a right lower lung mass which he suspected to be lung cancer, heart disease, hypertension, diabetes, and "restrictive lung disease secondary to pneumoconiosis and possible IPF, severe impairment." He listed the pneumoconiosis as "category 1" based upon an x-ray interpretation.

Dr. O'Bryan's opinion is not well reasoned. His opinion appears to be merely a restatement of his x-ray interpretation. The Board permits the discrediting of physician opinions amounting to no more than x-ray reading restatements. *See Worhach v. Director, OWCP*, 17 B.L.R. 1-105, 1-110 (1993) (citing *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-113 (1989), and *Taylor v. Brown Badgett, Inc.*, 8 B.L.R. 1-405 (1985)). In *Taylor*, the Board explained that the fact that a miner worked for a certain period of time in the coal mines alone "does not tend to establish that he does not have any respiratory disease arising out of coal mine employment." *Taylor*, 8 B.L.R. at 1-407. The Board went on to state that, when a doctor relies solely on a chest x-ray and a coal dust exposure history, a doctor's failure to explain how the duration of a miner's coal mine employment supports his diagnosis of the presence or absence of pneumoconiosis renders his or her opinion "merely a reading of an x-ray … and not a reasoned medical opinion." *Id.* As Dr. O'Bryan fails to state any other reasons for his diagnosis of pneumoconiosis beyond the x-ray and exposure history, I find his report neither well-reasoned nor well-documented. He further fails to take into account the Miner's 20-year smoking history. As such, I find the report of Dr. O'Bryan unreasoned and I afford it little weight.

Dr. Simpao[7] based his diagnosis on symptomatology, employment history, smoking history, family and individual medical histories, physical examination, chest x-ray, pulmonary function study, and arterial blood gas study. Based on the information gathered, Dr. Simpao diagnosed coal workers' pneumoconiosis, 2/2, based on a totality of the Miner's x-ray results, coal dust exposure history, pulmonary function results, along with physical findings and symptomatology.

Dr. Simpao utilizes all of the objective data collected to build and support a diagnosis of pneumoconiosis. He correctly stated the Miner's smoking history and incorporated it into his evaluation. While noting that Dr. Simpao lists no specialty credentials in the record, I find that Dr. Simpao's report is

[7] Dr. Simpao lists no medical specialty credentials.

based upon objective data. As such, I find it to be documented and reasoned and supportive of a finding of pneumoconiosis. I afford his opinion substantial weight.

Dr. Eric Norsworthy based his diagnosis on treatment of the Miner from 1986 through 1999. Based on the information gathered, Dr. Norsworthy diagnosed chronic obstructive pulmonary disease and coal workers' pneumoconiosis. He stated that his father, Dr. Robert Norsworthy, and Dr. Anderson had earlier diagnosed the Miner with pneumoconiosis, and that he relied upon those earlier diagnoses along with his x-ray interpretations and treatment to reach his own diagnosis.

"[T]he opinions of treating physicians are not necessarily entitled to greater weight than those of non-treating physicians in black lung litigation." *Eastover Mining Co. v. Williams,* 2003 WL 21756342 at *9 (6th Cir. July 31, 2003). "[I]n black lung litigation, the opinions of treating physicians get the deference they deserve based on their power to persuade." *Id.* "A highly qualified treating physician who has lengthy experience with a miner may deserve tremendous deference, whereas a treating physician without the right pulmonary certifications should have his opinion appropriately discounted." *Id.* In addition, appropriate weight should be given as to whether the treating physician's report is well reasoned and well documented. *See Peabody Coal Co. v. Groves*, 277 F.3d 829 (6th Cir. 2002); *McClendon v. Drummond Coal Co.*, 12 B.L.R. 2-108 (11th Cir. 1988).

Dr. Eric Norsworthy's opinion is neither persuasive nor well reasoned. Dr. Norsworthy appears to have relied upon his father's diagnosis and a chest x-ray. He does not reference any objective testing such as pulmonary function studies or arterial blood gas tests, nor does he reference or incorporate the Miner's significant smoking history or the Miner's duration of coal dust exposure into his opinion. Dr. Norsworthy lists no special medical credentials in the record. As such, he is not the "highly qualified" treating physician anticipated in *Eastover*, nor can he be given deference based upon the persuasiveness of his opinion. I find the opinion of Dr. Eric Norsworthy to be undocumented and unreasoned, and I afford it little weight in support of a finding of pneumoconiosis.

Dr. Anderson, a Board-certified Internist and Pulmonologist, reviewed symptomatology, employment history, smoking history, family and individual medical histories, physical examination, chest x-ray, pulmonary function study, and

arterial blood gas study evidence. Dr. Anderson diagnosed "category 2 pneumoconiosis" and heart disease. He based the pneumoconiosis diagnosis on the Miner's chest x-ray. He reversed his diagnosis during deposition, stating that after reviewing all the medical evidence, it was his opinion that the Miner did not have pneumoconiosis.

A diagnosis of pneumoconiosis based upon a chest x-ray is not a reasoned medical opinion. Section 718.202(a)(4); *Taylor*, *supra*. Further, Dr. Anderson reversed his pneumoconiosis diagnosis, but did not state the reasons or evidence relied upon in making that contrary diagnosis. It is proper to accord little probative value to a physician's opinion which is inconsistent with his or her earlier report or testimony. *Hopton v. U.S. Steel Corp.*, 7 B.L.R. 1-12 (1984) (a failure to explain inconsistencies between two reports rendered the physician's conclusions of little probative value); *Surma v. Rochester & Pittsburgh Coal Co.*, 6 B.L.R. 1-799 (1984) (physician's report discredited where he found total disability in an earlier report and then, without explanation, found no total disability in a report issued five years later). *See also, Brazzale v. Director, OWCP*, 803 F.2d 934 (8th Cir. 1986) (a physician's opinion may be found unreasoned given inconsistencies in the physician's testimony and other conflicting opinions of record). As Dr. Anderson presents inconsistent diagnoses of pneumoconiosis and fails to explain his reversal, I find Dr. Anderson's opinion to be undocumented, unreasoned, and I afford it little weight.

Dr. Gallo, a Board-certified Internist and Pulmonologist, reviewed symptomatology, employment history, smoking history, family and individual medical histories, physical examination results, chest x-ray, pulmonary function study, EKG, and arterial blood gas study. Based on the information gathered, Dr. Gallo diagnosed coal workers' pneumoconiosis, category 1p, and chronic bronchitis. He based his pneumoconiosis diagnosis on the Miner's years of exposure in the coal mining industry and on a chest x-ray. He listed no etiology for the chronic bronchitis.

A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v.*

Clinchfield Coal Co., 7 B.L.R. 1-295 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). Dr. Gallo did not base his diagnosis on the Claimant's medical histories or upon the objective data. As such, his diagnosis is undocumented. As discussed above, a diagnosis based upon coal dust exposure history and a positive x-ray interpretation is not a reasoned opinion. *Taylor*, supra.

Dr. Gallo also makes a possible legal pneumoconiosis diagnosis based upon chronic bronchitis, but he does not state that the bronchitis is caused by the Miner's coal dust exposure.

Dr. Gallo's clinical pneumoconiosis diagnosis is undocumented and unreasoned, and he fails to make the causal connection necessary to equate the Miner's chronic bronchitis with a legal pneumoconiosis diagnosis. I find Dr. Gallo's opinion not well reasoned, and I afford it little weight.

Dr. Lane, a Board-certified Internist, reviewed symptomatology, employment history, smoking history, family and individual medical histories, physical examination results, chest x-ray, pulmonary function study, EKG, and arterial blood gas study. Based on the information gathered, Dr. Lane diagnosed hypertensive cardiovascular disease, mild congestive heart failure, and chronic obstructive pulmonary disease with no objective evidence of pneumoconiosis.

Dr. Lane's 1983 report is well reasoned. He correctly noted the Miner's occupational and smoking histories and used them in conjunction with x-ray, pulmonary function, and arterial blood gas results to reach a documented, reasoned conclusion that the Miner did not suffer from pneumoconiosis. I note Dr. Lane's specialty as an Internist, and I afford his opinion substantial weight.

Dr. Robert Norsworthy,[8] the Miner's earlier treating physician, reviewed symptomatology, employment history, smoking history, family and individual medical histories, physical examination results, chest x-ray, pulmonary function study, and arterial blood gas study. Based on the information gathered, Dr. Lane diagnosed "early pneumoconiosis as evidenced from his symptomology [sic] and from his reduction in his PO2 to the lower functional limits at rest," as well as abnormal spirometry and history of exposure.

[8] Dr. Robert Norsworthy lists no medical specialty credentials in the record.

Dr. Norsworthy's report and diagnosis is based upon objective data and physical examination results. He correctly noted the Miner's employment and smoking histories, and he utilized all the information collected to make his diagnosis. While noting that Dr. Norsworthy does not have specialized medical credentials, I find this report well reasoned, based upon objective testing, and as such, I afford it great weight in support of a finding of pneumoconiosis.

The record also contains the reports and opinions of several consultative physicians. A nonexamining physician's opinion may constitute substantial evidence if it is corroborated by the opinion of an examining physician or by the evidence considered as a whole. *Newland v. Consolidation Coal Co.*, 6 B.L.R. 1-1286 (1984).

Dr. Fino, a Board-certified Internist and Pulmonologist, reviewed extensive medical evidence dating from 1988 through 1999. Based on his review, he opined that there was insufficient medical evidence to justify a diagnosis of simple coal workers' pneumoconiosis. He gave no explanation for his findings. An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1292 (1984). *See also, Phillips v. Director, OWCP*, 768 F.2d 982 (8th Cir. 1985); *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984); *Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983) (a report is properly discredited where the physician does not explain how underlying documentation supports his or her diagnosis); *Waxman v. Pittsburgh & Midway Coal Co.*, 4 B.L.R. 1-601 (1982). Dr. Fino offers an unsupported conclusion. As such, his opinion is unreasoned, and I afford it little weight.

Dr. Branscomb, a Board-certified Internist and Pulmonologist, also reviewed extensive reports and medical evidence generated from 1987 through 1999. He opined that the Miner "did not contract an occupational lung disease associated with coal mine employment." He offered no explanation for his findings. As with Dr. Fino, Dr. Branscomb offers only an unsupported medical conclusion, not a reasoned medical opinion. As such, I afford his findings little weight.

Dr. Caffrey, a Board-certified Anatomical and Clinical Pathologist, issued a 1999 consultative report in which he opined that he "could not objectively say" whether the Miner suffered from coal workers' pneumoconiosis. A physician's opinion may be given little weight if it is equivocal or vague.

Griffith v. Director, OWCP, 49 F.3d 184 (6th Cir. 1995) (treating physician's opinion entitled to little weight where he concluded that the miner "probably" had black lung disease); *see also, Justice v. Island Creek Coal Co.*, 11 B.L.R 1-91 (1988); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R 1-236 (1984). Dr. Caffrey was unable to make a determinative finding regarding the existence of pneumoconiosis and I, therefore, afford his opinion no weight either in support of or in discounting the existence of pneumoconiosis.

Dr. Hansbarger, Jr., a Board-certified Pathologist and Forensic Physician, issued a 1999 consultative report based on extensive review of objective testing data from the Miner. He opined that the Miner did not suffer from coal workers' pneumoconiosis or any other occupational pneumoconiosis based upon a review of the evidence, and specifically, Dr. Wiot's chest x-ray report. He explained that the Miner's lung cancer was related solely to the Miner's extensive smoking history, and he opined that the objective testing reviewed showed that the Miner's heart disease and chronic obstructive pulmonary disease were not consist with occupational coal dust exposure. As Dr. Hansbarger gave explanation and etiology for his diagnosis, and as he based his opinion on objective testing data, I find his opinion well reasoned and supportive of a finding of no pneumoconiosis.

Dr. Burki[9] opined in a 1998 consultative report that the Miner had no occupational disease. His finding of no pneumoconiosis was based upon chest radiographs indicating no pneumoconiosis and upon normal arterial blood gas readings. He opined that the spirometry tracings he reviewed were invalid due to poor effort. He further opined that the Miner's health issues focused on coronary artery disease.

Dr. Burki's report is well reasoned. His findings are based upon objective testing data and he reasonably discredited what he felt were invalid pulmonary function testing results from his opinion. He offered an alternative diagnosis for the Miner's health issues centering on coronary artery disease and not occupational lung disease. I find the consultative report of Dr. Burki well reasoned in support of a finding of no pneumoconiosis.

Dr. Anderson, a Board-certified Internist and Pulmonologist, issued a consultative report in 1986, nearly four

[9] Dr. Burki lists no medical specialty credentials in the record.

years after his direct examination of the Miner. Dr. Anderson opined that the Miner did not suffer from any permanent pulmonary impairment, but he did not address the issue of pneumoconiosis. An opinion which is silent on a particular issue is not probative of that issue. *See, e.g., Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000). As Dr. Anderson does not make a diagnosis regarding pneumoconiosis in his consultative report, I afford his opinion no weight either in support of or discounting the existence of pneumoconiosis.

Dr. O'Neill, a Board-certified Internist, reviewed medical data from 1982 and 1983. He was deposed in 1983 and he issued a consultative report in 1986. Dr. O'Neill opined that the Miner showed no evidence of pneumoconiosis and that the Miner instead suffered from chronic bronchitis due to cigarette smoking. He did not explain the basis of his findings. As stated above, an unsupported medical conclusion is not a reasoned diagnosis. *See Fuller, Duke*, *supra*. Dr. O'Neill's report is undocumented and unreasoned and I afford his opinion little weight on this issue.

In review of the physicians' opinions as a whole, I note that there are two time frames of opinions, those from the early 1980's and a second set of opinions generated in the late 1990's.

Drs. Lane and Robert Norsworthy offered well-reasoned opinions from the early 1980's. Dr. Lane, who offers superior credentials as a Board-certified Internist, diagnosed no pneumoconiosis. Dr. Robert Norsworthy, the Miner's treating physician at the time, diagnosed pneumoconiosis. As stated above, "a highly qualified treating physician who has lengthy experience with a miner may deserve tremendous deference, whereas a treating physician without the right pulmonary certifications should have his opinion appropriately discounted." *Eastover Mining Co.*, *supra*. Here, Dr. Robert Norsworthy lists no medical specialty credentials and the record is silent as to how long he was the Miner's treating physician. As such, I accord greater weight to the opinion of Dr. Lane, a Board-certified Internist, and find that the evidence from the 1980's does not support a finding of pneumoconiosis.

Because pneumoconiosis is a progressive and irreversible disease, it may be appropriate to accord greater weight to the most recent evidence of record, especially here, where a significant amount of time separates newer evidence from that evidence which is older. *Clark v. Karst-Robbins Coal Co.*, 12

B.L.R. 1-149 (1989) (*en banc*); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). *See also, Crace v. Kentland-Elkhorn Coal Corp.*, 109 F.3d 1163 (6th Cir. 1997) (stating that "recent evidence is particularly important in black lung cases, where because of the progressive nature of pneumoconiosis, more recent evidence is often accorded more weight").

Of the later collected evidence, Drs. Burki, Hansbarger, and Simpao offer well-reasoned opinions from the late 1990's. Drs. Burki and Hansbarger opined that the Miner did not suffer from pneumoconiosis, while Dr. Simpao felt that the objective data did support such a diagnosis. None of these physicians lists pulmonary specialty credentials. I accord more weight to the combined opinions of Drs. Burki and Hansbarger over the single opinion of Dr. Simpao, and I find that the most recent evidence does not support a finding of pneumoconiosis.

Taken as a whole, I find that the medical opinion evidence does not support a finding of pneumoconiosis. Accordingly, I find that the Claimant has not established the existence of pneumoconiosis under § 718.202(a)(4).

Because the Claimant has not established the existence of pneumoconiosis in the Miner, the question of whether it is caused by coal mine employment is moot. Further, although the Claimant has proven above that the Miner was totally disabled, she cannot prove that the Miner's disability was caused by his pneumoconiosis. As such, the Miner's duplicate claim must fail.

Survivor's Claim

In review of the Claimant's survivor's claim, the Board affirmed the finding that the Miner's death was not due to pneumoconiosis pursuant to § 718.205(c). *Devine*, BRB No. 02-0669 BLA at 7. In order to establish entitlement to benefits pursuant to 20 C.F.R. Part 718 in a survivor's claim filed after January 1, 1982, the claimant must establish that the miner suffered from pneumoconiosis arising out of coal mine employment and that the miner's death was due to pneumoconiosis or that pneumoconiosis was a substantially contributing cause of death. Twenty C.F.R. § 718.205(c). As the Board affirmed my holding that the Miner's death was not due to pneumoconiosis, the Survivor's claim must fail as a matter of law without further review.

Entitlement

Carrie E. Devine, the Claimant, has not established entitlement to benefits under the Act.

Attorney's Fee

The award of an attorney's fee is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for representation services rendered in pursuit of the claim.

ORDER

It is, therefore,

ORDERED that the claims of Carrie E. Devine, Widow of, and on behalf of the Estate of George M. Devine, Jr., for benefits under the Act are hereby DENIED.

A

Robert L. Hillyard
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C., 20013-7601. A copy of a Notice of Appeal must also be served upon Donald S. Shire, Esq., 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C., 20210.